CHAPTER 67:16:11

EARLY & PERIODIC SCREENING, DIAGNOSIS, & TREATMENT

67:16:11:01. Definitions. Terms used in this chapter mean:

(1) "Clinical record," a written record of the individual's care;

(6) "Early and periodic screening, diagnosis, and treatment" or "EPSDT," screening and diagnostic services available to eligible individuals under 21 years of age to determine physical or mental status and provide health care treatment and other measures to correct or ameliorate defects or chronic conditions discovered;

(8) "Extended home health aide services," those nursing-related services not required to be performed by a licensed health professional but prescribed by a licensed physician;

(12) "Plan of care," the written plan developed by a licensed nurse in response to the attending physician's written order to the nurse prescribing the needed services and the duration of those services;

(13) "Private duty nursing," nursing services as defined in SDCL 36-9-3 for technology-dependent individuals who require more than three consecutive hours of patient care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or nursing facility;

(16) "Screening," the use of examination procedures to determine the existence of certain physical or mental illnesses or conditions;

(17) "Technology-dependent individual," an individual who relies on life-sustaining medical technology to compensate for the loss of a vital body function and requires ongoing, complex, hospital-level nursing care to avert death or further disability;

67:16:11:03. Covered services.

(15) Home health services when the requirements of § 67:16:11:03.19 have been met;

(16) Private duty nursing services when the requirements of §§ 67:16:11:03.20 and 67:16:11:03.22 have been met; and

(17) Extended home health aide services when the requirements of 67:16:11:03.21 have been met.

67:16:11:03.19. Home health services. Home health services are covered when the requirements of chapter 67:16:05 are met, with the following exceptions:

(1) The child does not have to be confined to the home; however, the child must have a medical condition caused by an illness or injury which requires a considerable effort and the assistance of another individual or the aid of supportive devices to leave the home; and

(2) There is no limit on the number of home health aide services in each calendar quarter.

67:16:11:03.20. Private duty nursing services. Private duty nursing services for a technology-dependent individual are covered when the following requirements are met:

(1) The services are medically necessary: ARSD 67:16:01:06.02.;

(2) The services are provided by a home health agency or, if a home health agency is not available in the area to provide the services, by a nurse licensed under the provisions of SDCL chapter 36-9. The department must have a written denial of services from the home health agency before the nurse delivers the services and the nursing services must meet the provisions of 42 C.F.R. § 440.70;

(3) The services are provided in the individual's residence, school setting, hospital, or nursing facility. For the purpose of this rule, an individual's residence does not include an intermediate care facility for the mentally retarded or an institution for individuals with a mental disease;

(4) The services are provided to an individual requiring more than three consecutive hours of patient care or more patient care than is routinely provided by the nursing staff of a hospital or nursing facility;

(5) The services are prescribed by the individual's attending physician and contained in the individual's plan of care; and

(6) The services are authorized by the department before they are provided.

The individual's record must contain written documentation verifying that these requirements have been met.

67:16:11:03.22. Private duty nursing services -- Extended home health aide services: Prior authorization -- Reauthorization. A provider must have authorization from the department before providing either private duty nursing services or extended home health aide services. The provider must submit to the department a written plan of care which has been reviewed and signed by the attending physician. The department's authorization is based on its review of the required documentation to determine if the conditions for payment have been met. The department may verbally authorize services after the plan of care is submitted; however, the department shall verify a verbal authorization in writing before the services are paid.

An authorization may not exceed two months. The provider may request reauthorization by submitting an updated plan of care and the physician's recertification indicating the need for continued private duty nursing services or extended home health aide services.

67:16:11:06.14. Rate of payment -- Home health services. Payment for home health services shall be made according to chapter 67:16:05.

67:16:11:06.15. Rate of payment -- Private duty nursing services. Payment for private duty nursing services is limited to the lesser of the provider's usual and customary charge or the fee contained in the following table:

CODE	PROCEDURE	FEE
H5190	Private duty nursing - registered nurse	22.45/hr
W1010	Private duty nursing - licensed practical nurse	18.03/hr

67:16:11:06.16. Rate of payment -- Extended home health aide services. Payment for extended home health aide services is limited to the lesser of the provider's usual and customary charge or the fee contained in the following table:

CODE	PROCEDURE	FEE
W1000	Extended home health aide service	$12.85/hr

67:16:11:08. Services not covered under EPSDT. Services which are not covered under the EPSDT program include the following:

(1) Services which are determined by the state medical consultant or dental contractor to be not necessary, safe, or effective;

(2) Diagnosis or treatment given in the absence of the recipient;

(3) Attendance of two providers, with the exception of physicians, on the same case at the same time, unless approved by the department;

(4) Services provided by an employee of federal, state, or county government. This does not include employees of the public health service or the national health service;

(5) Services, procedures, or drugs which are considered experimental;

(6) Cosmetic surgery or services to improve the appearance of an individual when not incidental to prompt repair following an accidental injury, or any cosmetic surgery or service which goes beyond that which is necessary for the improvement of the functioning of a malformed body member;

(7) Drugs and biologicals which the federal government has determined to be less than effective as listed in subdivision 67:16:14:05(13); and

(8) Self-help devices, exercise equipment, protective outerwear, and personal comfort or environmental control equipment such as air conditioners, humidifiers, dehumidifiers, heaters, or furnaces.

67:16:11:08.01. Cost not to exceed long-term institutional care. When the actual or projected cost of all services provided in the home over a period of three months exceeds 135 percent of the cost of care if the individual was institutionalized in a long-term care facility, the department shall issue a notice of intent to discontinue or deny further service. The notice shall be sent to the provider and to the individual. If within 60 days after the notice the provider furnishes documentation that the future service costs in the home will decline and be within 135 percent of the cost of long-term care, the department shall reconsider its decision.

67:16:11:11. Utilization review. Utilization review for EPSDT services may be conducted on three levels:

(1) Computerized claims processing;

(2) Postpayment review; and

(3) Peer review.

67:16:11:14. Claim requirements. A claim for services covered under this chapter must be submitted according to the following requirements:

(10) For home health services, follow the claim requirements of § 67:16:05:09;

(11) For private duty nursing, include the applicable procedure code contained in § 67:16:11:06.15 and follow the claim requirements of § 67:16:11:19.02;

(12) For extended home health aide services, include the procedure code W1000 and follow the claim requirements of § 67:16:11:19.02; and

67:16:11:19.02. Claim requirements -- Private duty nursing -- Extended home health aide services. A claim for private duty nursing and extended home health aide services provided in this chapter must be submitted on a form which contains the following information:

(1) The recipient's full name;

(2) The recipient's medical assistance identification number;

(3) Third-party liability information required under chapter 67:16:26;

(4) Date of service;

(5) Place of service;

(6) The provider's usual and customary charge. The provider may not subtract other third-party payments from this charge;

(7) The applicable procedure codes for the services covered;

(8) The applicable diagnostic codes as contained in the ICD-9-CM;

(9) The units of service furnished, if more than one;

(10) The provider's name and medical assistance identification number; and

(11) The prior authorization number issued by the department.

A separate claim form must be used for each recipient.

Note: The HCFA 1500 form substantially meets the requirements of this rule and its content and appearance are acceptable to the department.